2005 Special Needs Registry

Individuals are eligible to be registered with the Special Needs Registry if they are 60 years of age or older, frail, elderly, medically needy, and/or disabled and are not served in or by a residential facility program. Eligible clients are required to complete and sign this application as well as the HIPAA Disclosure of Information and HIPAA Privacy Act forms before they will be placed on the registry.

Social Security Number ____-___-_____

Last Name _____First _____Middle Initial _____

Physical Address _____Key _____

Mailing Address (if different) _____City_____Zip _____

Do you plan to evacuate to a public shelter? ----------Y_____ N _____
Do you need Monroe County to transport you to a shelter? ---------- Y_____ N _____
(**If you answered *no* to both of the above, you will not be registered and need only to sign the back of the form. If you answered *yes* to either or both please continue to complete the form front and back.)**
If you do not have a phone, you must list a neighbor's phone number that we may use to contact you.
Nearest Mile Marker _____Home Phone#_____ Spanish only? Y ____N____
Sex M_____ F _____Date of Birth _____

If married: Name of Spouse _____Is Spouse registered? Y____N____

Residence type (**please check one**): Single family home/Duplex _____ Apartment _____ Boat _____
Condo _____ Campground/RV _____ Mobile Home _____ Other _____

Number of Pets in home: Dog _____ Cat _____ Other (type & #) _____
(**NOTE: Pets of Special Needs Registry clients are eligible to, if pre-registered, accompany clients to shelter when pet-friendly sheltering is available.**
However, arrangements must be made in advance of the client's pick-up)
Category storm you need transportation for 1 & 2 _____ 3 or higher _____ All _____
Are you a year round resident _____ or a seasonal resident ____Name months you are in county _____
Can you sit up and ride in a bus or van? ---------- Y _____ N _____
Do you need a wheelchair lift? ---------- Y _____ N _____
Do you require an ambulance for transportation? ---------- Y _____ N _____
(*If yes, you will be contacted by Emergency Medical Services to assess your condition.*)
Are you receiving home health care? ---------- Y_____ N _____
If yes, name of agency-- _____

If you have a required caregiver, please list their name and phone number.
Name _____ Phone number _____
Total number of people that will accompany you to a shelter _____

You <u>must</u> give name & phone number of a neighbor or friend that we may use for an alternate contact: This person must live in your area & must be aware that they are listed as an alternate contact!
Name _____ Phone _____

********************************TO BE FILLED OUT BY REFERRING AGENCY ********************************
Agency Name: _____
Location & Phone Number: _____
New Client _____ Update Existing Client _____ Delete _____ (reason) _____

Please check all that apply to your condition:		**Are you dependant on any of the following:**	
No disabilities		*Catheters*	
Alzheimer's – ***please note stage***		*Contagious disease (please specify)*	
Ameliorating Lateral Sclerosis(ALS)		*Dementia*	
Back Injury		*Electricity*	
Blind / Hearing or Speech Impaired		*I.V. Medication*	
Cerebral Palsy		*Mental Illness (please specify)*	
Colostomy or Ileostomy ***specify***		*NG tube/CV infusion site/tracheostomy*	
Epilepsy/other seizures ***specify***		*Oxygen/COPD/Emphysema*	
Fractured Bones with pin care		*Respirator*	
Full Paralysis		Dialysis - *no dialysis is available on site*	
Heart Condition		Insulin	
High blood pressure		**About Your Mobility:**	
On special diet		Ambulatory(can get around on your own)	
Pregnant, in 7th month or more		Ambulatory with assistance	
Severe arthritis		Walker / Cane / Crutches	
Terminal condition		Wheelchair	
Is Shelter Assistance Needed For: (ADL) (Circle those that apply) Communications Feeding Dressing changes Medication		*Non-Ambulatory (bedridden)*	
		Wheelchair bound	

Other Disabilities **including incontinence or knee or hip replacement in the past 6 months, etc.**
Please list:

The information contained herein is true and correct to the best of my knowledge. I have read the information sheet attached and I understand the limitation on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I also grant permission to emergency personnel to enter my home following an emergency if deemed necessary by proper authorities. I understand that this registration is voluntary and hereby request registration in the Special Needs Registry (SNR). I understand that all information given will be held in strict confidence and will be used for emergencies only. I also understand that it is my responsibility to keep my information current with SNR by completing annual renewals and providing updates as my condition changes.

X_____ Date _____
Signature of Client Date of Signature

**********FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE **********

Evac zone _____ EMS Zone _____ Date contacted _____

Transport to: Hospital _____ Nursing Home _____ Special Needs Shelter _____

HIPAA Forms Y____ N____ Transport by: EMS _____Social Service_____

Please return to the following**: Special Needs Registry**
Monroe County Transportation
1100 Simonton Street Room 1-180
Key West, FL 33040